Date: May 8, 2018
To: All Minnesota Health Plan Companies
Re: Supplemental Guidance – 2019 Health Insurance Filings

On April 6, 2018, the Minnesota Department of Commerce and Minnesota Department of Health (Departments) provided Preliminary Guidance for health insurance filing for plans that will be offered, sold, issued or renewed in Minnesota on or after January 1, 2019 (Plan Year 2019). This letter provides additional and supplemental guidance from the Departments and MNsure for health insurance filings for Plan Year 2019.

In the Preliminary Guidance letter, the Departments indicated that supplemental guidance would be provided following the release of the Notice of Benefits and Payment Parameters (NBPP). On April 9, 2018, the Centers for Medicare and Medicaid Services (CMS) issued the final 2019 NBPP. This Supplemental Guidance letter provides guidance from the Departments pursuant to the 2019 NBPP.

On April 17, 2018, the Minnesota Council of Health Plans (MCHP) provided feedback and sought clarification to several provisions contained in the Preliminary Guidance letter. Where applicable, clarification has been provided in this Supplemental Guidance letter.

The requirements contained in both the Preliminary Guidance and this Supplemental Guidance letters will be included in the review of filings conducted by the Departments for Plan Year 2019. The Departments and MNsure will continue to review health plan filings to ensure compliance with all applicable state and federal requirements, including Minnesota Statutes and the Affordable Care Act (ACA). Information and materials related to the Preliminary and Supplemental Guidance are subject to change as corresponding Minnesota and Federal regulations are modified.

**Deadlines**

There are no changes to the deadlines contained in the April 6, 2018 Preliminary Guidance letter.

For clarification, consistent with Minn. Stat. §60A.08, subd. 15(g), proposed rate data will be posted via SERFF ten business days after proposed rates are filed with the Department of Commerce. The deadline for proposed rates for Plan Year 2019 is June 1, 2018. Therefore, proposed rates will be posted in SERFF on June 15, 2018. Final rate data will be posted via SERFF no later than 30 days prior to the beginning of the open enrollment period, per Minn. Stat. §62A.02, subd. 2(c). This is anticipated to occur on October 1 or October 2, 2018.
Further, CMS has stated that information on proposed 2019 rate increases will be publicly available via healthcare.gov on August 1, 2018, and final rates will be publicly available on healthcare.gov on November 1, 2018.

Supplemental Guidance on 2019 Federal Changes

Cost-Sharing Reductions

Please refer to the April 6, 2018 letter for guidance regarding cost-sharing reductions. In the event that cost-sharing reduction payments are made for Plan Year 2019, upon request, the Department of Commerce will work individually with each health plan company actuary to ensure regulatory compliance.

Preventive Services

Health plan companies must provide adequate disclosure to enrollees of all benefits, including basic preventive services covered by United States Preventive Services Task Force (USPSTF) recommendations. The Departments have broad discretion to determine which benefits and consumer rights require disclosure in certificates of coverage (CoCs) and favor broad inclusion of information to enrollees.

In the past, the Departments have reviewed CoCs which state only that coverage is provided consistent with USPSTF A and B guidelines. This approach has not provided adequate information to consumers and requires that consumers and enrollees seek out information from multiple documents or on the internet.

In response to MCHP concerns, the Departments provide the following clarification regarding the disclosure of preventative services in CoCs:

- Health plan companies should provide a sufficient level of detail about all preventive services, including children’s preventive services and women’s preventive services in the CoC.
- If a health plan company has concerns about the level of detail required by specific items, it is encouraged to discuss these issues with forms reviewers during the binder process.

Contraception Coverage Exemption

MCHP requested clarification on required language for contraception exemptions and accommodations in certificates of coverage for “religious employer” and “eligible organizations.” The Department of Health clarifies that accommodation language, which informs enrollees how to receive contraceptives with no cost-sharing, is only required for “eligible organizations,” and not “religious employers” per 45 CFR §147.131. If one CoC form is used for all small group products, there should be variable language for both religious employer exemptions and eligible organization accommodations. If a health plan company has specific questions, it is encouraged to discuss these issues with forms reviewers during the binder process. In addition, the Annual Instructions Guide has been updated to reflect contraception exemption guidance.
Supplemental Guidance on State Law

Mental Health Parity

In response to MCHP concerns, the Departments provide the following clarification regarding mental health parity requirements:

- Health plan companies should include a brief statement about the mental health parity law and the purpose of the law so enrollees are aware of mental health parity rights in CoCs. This requirement is consistent with the disclosure provided last year by HMOs in CoCs.

- If a health plan company has a specific concern about whether inclusion of certain language is necessary or unduly confusing, the health plan company is encouraged to raise this concern during the forms review process.

- Consistent with the Preliminary Guidance letter, health plans should fully incorporate federal mental health parity requirements into their plan design and meet all of the financial requirements under the final rules released on November 13, 2013 for individual and small group plans.

Network Adequacy Waiver Requirements

Minn. Stat. §62K.10 gives the Commissioner of Health clear authority to determine when health plan companies have demonstrated that “it is not feasible” to meet geographic access requirements and to establish criteria for waivers. The Department of Health’s (MDH) changes to waiver reason codes are fully consistent with this authority.

The provider waiver code reasons for 2019 provider networks are not new. Historically, three waiver codes were used as a basis for granting waivers to geographic access standards (no providers physically present, providers physically present but do not meet credentialing requirements, and provider refused to contract). A fourth reason code, “other,” was allowed from 2016 – 2018. However, MDH has determined that criteria for this reason code were unclear. If health plan companies have specific concerns about use of this code, they should address it with MDH staff during network adequacy review.

Minn. Stat. §62K.10 clearly requires health plan companies to, “demonstrate with specific data,” that compliance with geographic access is not feasible. Updated instructions stated on the Request for Waiver form provide guidance on the type of evidence needed to establish the basis for granting a waiver.
2019 Notice of Benefit Payment Parameters (2019 NBPP)\(^1\)

Health plan companies are encouraged to review the 2019 Notice of Benefit Payment Parameters (NBPP). This Guidance references some key provisions that may be the most helpful for Minnesota health plan companies.

- Based on the 2019 NBPP and in accordance with 45 CFR §155.410, the individual market open enrollment period is November 1, 2018 through December 15, 2018. If the timeframe is extended due to state legislation or supplemented via a special enrollment period due to MNsure Board action, communications will be sent to all health plan companies participating in the individual market via SERFF for guidance if a change results in filing adjustments.

- The 2019 maximum annual limitation on cost sharing is $7,900 for self-only coverage and $15,800 for other than self-only coverage.
  
  - The Internal Revenue Service thresholds for high deductible health plans compatible with a health savings account has yet to be released, but are expected shortly.
  
  - Note that the Internal Revenue Service recently released Revenue Procedure 2018-27 (which will be IRB 2018-20 on May 14), which provides relief for taxpayers with family coverage under high deductible health plans concerning the annual deductible contributions limit for their 2018 health savings accounts.\(^2\)

- The rate threshold for Part II justification narrative submissions to HIOS (also known as “healthcare.gov”) has increased from 10 percent to 15 percent. Under Minn. Stat. §62A.02, subd. 3, Minnesota regulators review all health rate filings, regardless of the product, market segment, rate increase magnitude, and regardless of whether a health plan company is new to Minnesota or not.

- The 2019 Essential Health Benefits (EHB) plan continues to be based on 2014 Health Partners Gold Open Access Choice.

- The pediatric dental EHB benchmark continues to be the Federal Employees Dental and Vision Plan (FEDVIP), MetLife Federal Dental Plan-High Option.

- Under State law, the Departments do not have the authority to make changes to the EHB benchmark. Therefore, the Departments will not apply to federal regulators to allow plans to make actuarially equivalent coverage exchanges between the ten essential health benefit categories for plan year 2020. Health plan companies may perform actuarial equivalent coverage exchanges within any of the ten essential health benefits categories.

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• The Departments do not plan to apply to federal regulators to revise Federal Minimum Loss Ratio requirements.

• The Departments do not plan to apply to federal regulators to prorate risk adjustment transfers. Health plan companies may choose to discuss with Commerce actuaries whether such a proration is justified based on their own analysis. The deadline for a state to communicate a plan year 2020 risk transfer proration to federal regulators is August 1, 2018.

• The 2019 NBPP describes a new model for a leaner version of the Small Business Health Options Program (SHOP). Health plans are encouraged to discuss with MNsure how this model could be operationalized before finalizing/filing SHOP plans in Minnesota.

• MNsure will continue to support a robust, localized network of navigator partners in Minnesota to ensure consumers can find a navigator in their community.

• Certified standalone dental plans no longer need to comply with actuarial value requirements (formerly, 70%+.2% for “low” plans and 85%+.2% for “high” plans). Designs can be more flexible, though the plan must still meet the federal $350/$700 out of pocket maximum requirement. The actuary still must provide the basis and value for each plan’s actuarial value within the actuarial memorandum, along with the Actuarial Value Supporting Documentation and Justification.

Plan Management General Instruction Guidance

Ongoing operational and administrative instructions of Minnesota’s rate, form and binder requirements are provided within the Minnesota Plan Management General Instructions found on SERFF. The major plan management changes since last year are as follows:

• The SERFF Change Request Form has been modified.

• The Annual Instructions Guide has been updated, with the following highlighted additions:
  o Information relating to controlled group renewals
  o Information relating to new and changed templates and attestations
  o Instructions on how to use SERFF to show accreditation (new process)
  o Information relating to the contraception coverage exemption and federal injunction
  o Many small group regulations cited directly in the guide
  o Processes for post-approval small group quarterly rate changes, and
  o Processes for post-approval small group plan additions.
• The Out of Network Experience Template has been expanded to include additional breakouts for mental health and substance use disorder. This information will aid the Departments in targeting network adequacy reviews and collecting data that may assist with parity concerns.

• The Service Area Withdrawal Template has been added to readily identify health plan companies withdrawing from any county served in the prior year. The template requires information on the transition plan, including how the health plan company will notify enrollees of the termination and coverage options available to terminated enrollees.

• Based on federal changes, the State-based Exchange Issuer Attestation has been updated to include language regarding the segregation of funds relating to certain claims.

• A Plan Design Actuarial Attestation was added to better demonstrate compliance with the many plan design parameter requirements of the Affordable Care Act.

• The Enrollment Cap Request Template was revised to remove the analysis for an alternative enrollment cap request if there were no reinsurance program in place. Further, the Annual Instructions Guide was updated to explain reporting requirements if an on-exchange issuer hits an enrollment cap when a partial county service area is in place.

• Health plan companies are reminded to contract with a sufficient number of Medication-Assisted Treatment providers that are SAMSHA-certified in order to provide opioid treatment programs, since these providers are the only providers who can prescribe methadone. Health plan companies should also assure that in-network coverage provides sufficient access to other medication assisted treatment providers. Network review staff will send objections if there is not evidence of sufficient access to various types of opioid treatment program modalities.

• Health plan companies should report Residential Treatment facilities in the provider network file as part of their network adequacy submission. NCQA defines “residential” treatment as “a facility or a discrete part of a facility that provides a 24 hour therapeutically planned and professionally staffed group living and learning environment to live-in residents who require psychiatric care or substance abuse treatment, but do not require acute medical care.” “Residential programs” are also defined in Minn. Stat. §245A.02, subd. 14. The departments recognize that residential treatment has generally been reported in the provider file. The new provider type code "RT" will allow these facilities to be more easily identified. Details on how to report Residential Treatment can be found in the Detailed Provider Network Adequacy instructions.

• SERFF has adopted a new pricing structure: http://serff.com/serff_newsletter.htm.
• The Department of Commerce has several additional templates for insurers and health service corporations that are used to monitor compliance (the Drug Formulary Process Attestation, the Contraceptive Services Attestation and the Provider Contract Attestation template do not apply to HMOs):

  o Drug Formulary Process Attestation - The form has been changed to remove provisions that no longer apply, but other relevant compliance topics have been added.
  o Minimum Contribution and Minimum Participation Template – NEW - small group only
  o Contraceptive Services Attestation – NEW - shows categories’ 100 percent coverage item(s)
  o Provider Contract Attestation - The form has been changed to remove provisions that no longer apply, but other relevant compliance topics have been added.

Dental Certification Guidelines

For 2019, MNsure will be releasing updated Dental Plan Certification Guidance. The guidance has been revised to include new federal and state requirements and further clarifications to language used from the previous guidance where appropriate. When posted, the revised guidance can be found on the following link: https://www.mnsure.org/shop-compare/about-plans/plan-certification/index.jsp.

Parity and Non-Quantitative Treatment Limits (NQTLs)

As part of the Departments’ continued focus on mental health and substance use disorder parity enforcement under federal law, a request for information will be made for one NQTL each year. In order to manage administrative burdens, this activity will occur after filings have been approved. While the NQTL for 2019 has not yet been selected, it will likely fall under one of the following NQTL categories: Prior authorization, medical necessity, network access, or provider reimbursement.

Please contact Maybeth Moses (Commerce) at maybeth.moses@state.mn.us or Tom Major (Health) at tom.major@state.mn.us if you have any questions about the process or requirements.

Sincerely,

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